



APPLICATION FOR APPROVAL OF AN INDIVIDUAL OR ORGANIZATION TO PROVIDE CONTINUING EDUCATION COURSES FOR DENTISTS AND DENTAL HYGIENISTS

State Form 50327 (R / 2-06)

Approved by State Board of Accounts, 2006

RETURN THIS APPLICATION TO:
INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
 402 West Washington Street, Room 072
 Indianapolis, Indiana 46204
 Telephone: (317) 234-2057
 E-mail: pla7@pla.IN.gov

FOR AGENCY USE ONLY:		
Receipt number	Fee paid	Date paid (month, day, year)
Date reviewed (month, day, year)	Decision:	Initials

PLEASE TYPE OR PRINT LEGIBLY

Name of individual or organization	Type of application <input type="checkbox"/> New Application <input type="checkbox"/> Renewal	
Applying as an: <input type="checkbox"/> Individual <input type="checkbox"/> Organization	The individual or organization will provide courses for: <input type="checkbox"/> Dentists <input type="checkbox"/> Dental Hygienists	
Address (number and street, city, state, and ZIP code)		
Daytime telephone number ()	E-mail address	Web address
SIGNATURE OF AUTHORIZED INDIVIDUAL		
Printed name of authorized individual	Signature of authorized individual	
Title	Date signed (month, day, year)	
Telephone number ()	E-mail address	Fax number ()

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency, or Indiana State Board of Dentistry, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board or any of their authorized representatives in connection with processing this application for approval of a individual or organization to provide continuing education courses.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Indiana State Board of Dentistry to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Printed name of authorized individual	Signature of authorized individual	
Title	Date signed (month, day, year)	

NOTICE

In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain information maintained by this agency. The information you provide will become public record.